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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 28, 2012 through October 10, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 34. The stage two survey sample was twenty five (25).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F157 483.10 (b) Notify of Changes (Injury/Decline/Room, etc.) 1. R8's MD or family notification cannot be completed retrospectively due to timeframe of occurrence, 8/1/12 2. All residents are at potential risk of weight loss and not having the MD or family notified. The facility revised and will be utilizing a Monthly/Weekly Weight Recap Sheet for each resident that evaluates significant weight changes and a designated area on the form to document MD (physician) and family notification (Attachment A). — 11/26/12 3. All nurses will be inserviced on the Monthly/Weekly Weight Recap Sheet and proper monitoring and utilization. — 11/30/12 4. Random sample audits will be completed to verify MD (physician) and family notification on significant weight changes. Audits will be completed monthly and reported at Quarterly QI (Attachment B). — 12/15/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Associate Executive Director 11/8/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that for one (R8) of 25 residents reviewed, the facility failed to immediately consult with the physician and immediately notify R8 ' s family about her severe weight loss. Findings include: Cross refer F325 example number 2 R8 was readmitted to the facility on 6/17/12 with diagnosis that included cerebral vascular accident, respiratory failure with intubation and urosepsis. Record review revealed a vital signs and weight flow sheet that was completed by a nurse. This document revealed that on 7/1/12 a weight of 180.6 pounds (#) was obtained and on 8/1/12 a weight of 162.6 # was obtained. This was a severe weight loss because R8 lost greater than 5% of her body weight in 1 month. Record review lacked evidence that the physician was immediately consulted about the severe 18 pound weight loss experienced by R8. The first indication that the physician had been consulted concerning the severe weight loss occurred in the form of a physician ' s order on 8/13/12. This order incorporated interventions such as	F 157		

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F 157	Continued From page 2 increased cueing and assistance with meals and the initiation of weekly weights. Subsequently the physician documented on 8/16/12 a weight of 162.6 in his progress note. The medical record lacked evidence that R8 ' s family was ever made aware of the severe weight loss that was initially documented on 8/1/12. On 10/9/12 at approximately 1:00 PM, E2 (Director of Nursing) and E3 (Assistant Director of Nursing) confirmed that R8 ' s family had not been notified of the severe weight loss. Findings reviewed with E1 (Administrator), E2 and E3 on 10/10/12 at approximately 11:00 AM.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for three (R42, R44 and R79) of 25 sampled residents. Findings include: 1a. On 10/1/12 at 9:45 AM R79 was observed sitting in his wheelchair in the common area outside the dining room. R79's trousers were	F 241	F241 483.15 (a) Dignity and Respect of Individuality 1. R42 expired on 10/17/12. R44 was transferred and discharged back to Assisted Living on 10/4/12. The facility cannot retroactively correct R79's inappropriate dress of shirt being unbuttoned and trousers repositioned to secure brief due to a 10/1/12 date of occurrence. The facility cannot correct the timeliness of wiping R79's nasal nares; however, R79's nasal nares was attended to after 1 minute after being observed by a surveyor by E21 (Activity Assistant). R79 cannot be retroactively asked permission to wear clothing protector.	10/11/12

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F 241	Continued From page 3 open in the front exposing his incontinent pad, his shirt was not buttoned. R79 was in plain view of everyone in the common area. 1b. On 10/3/12 at 9:05 AM R79 was observed in the dining room sitting alone, facing the wall with his chin resting on his chest. R79 had thin clear mucous hanging from his nose extending approximately 4 inches. At 9:12 AM E22 (Certified Nursing Assistant/CNA) approached R79 removed his clothing protector and wheeled him into the common area outside the dining room. The mucus was still present. At 9:13 AM E21 (Activity Assistant) noticed the mucus and offered R79 a tissue to wipe his nose. 1c. On 10/3/12 at 11:28 AM R79 was brought into the dining room. A clothing protector was placed on the resident without asking permission. R79 reached back and was attempting to unfasten the velcro closure. 1.d. Throughout the survey R79 was observed during meals to be seated alone at a table, facing the wall and was using plastic forks and spoons was servered beverages in stryofoam cups and soup in styrofoam bowls. R79 was only offered paper napkins. Other residents in the dining room were observed to be using cloth napkins, and were not using disposable spoons, forks, cups or dishes. Staff interview on 10/9/12 at 11:30 AM with E3 (Assistant Director of Nursing) confirmed that R79 was seated alone and was using plastic forks and spoons and other disposable items because he throws things and they could not risk having him hurt someone.	F 241	R79 had his seating changed to face other residents and placed for socialization. R79 received new orders on 10/11/12 as follows: "Due to resident poking self with fork and knife, only use plastic ware." Also, another new order for R79 on 10/11/12 as follows: "Finger food as much as possible." (Attachment C). R79's care plan was revised to include order changes per Attachment C (Attachment D). 2. The facility will provide tissues in the resident dining room for use by residents or staff as needed. Residents will be checked prior to entering the dining room with adjustments made to clothes accordingly. Residents seating is readjusted to a position that is condusive to socialization. A laminated sign placed on the clothing protector cart with letters "DYA," meaning "Did You Ask" prompt staff to ask resident permission prior to application of clothing protector (Attachment E). The facility will review with the MD/ physician any resident requiring plastic utensils and/or styrofoam disposable items prior to initiating and an order will be written. The facility will also update the plan of care when a resident requires plastic utensils or styrofoam disposal ware. The facility will implement a laminated pictoral of a "SKATE," which means "Stop, Knock, Ask To	11/26/12

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F 241	Continued From page 4 2. On 10/1/12 at 9:23 AM R44 was in her room with the surveyor with the door closed. E17 (CNA) opened R44's door, entered the room without knocking or asking for permission to enter R44's room. E17 asked R44 if she could take her breakfast tray. E17 took the breakfast tray and left the room. 3. Observation on 10/4/12 at 9:15 AM revealed that E23, nurse, and E22, CNA, both entered R42's room without knocking, one to pick up breakfast tray and one to provide care. The resident was in bed watching TV.	F 241	Enter." The laminated "SKATE" will be placed on the metallic door jam of each resident room (Attachment F). 3. All staff will be inserviced on tissues in dining room, inspection of residents prior to entering dining for proper dress, (i.e. shirts buttoned, briefs secured, etc.) "DYA," "Did You Ask," to apply clothing protector, proper seating of residents to support socialization and "SKATE," "Stop, Knock, Ask To Enter" and knowledge of location of laminated cues. 4. Random audits will be done monthly to evaluate resident seating arrangement conducive to socialization, resident dressed appropriately, nasal/oral cavity clean, "DYA" (Did You Ask) prior to applying clothing protector, follow "SKATE" (Stop, Knock, Ask To Enter) (Attachment H).	11/30/12 12/15/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that one (R42) out of 25 sampled residents was not accommodated with a call bell that was in reach. Findings include: R42 had a fall care plan, dated 10/5/11 and last updated 4/4/12, that included the approach "keep my call bell within reach and answer as promptly as possible". Observation on 9/28/12 at about 10:30 AM,	F 246	F246 483.15 (3) (1) Reasonable Accommodation of Needs/Preferences 1. R42's call bell was readjusted and placed within reach and R42 was instructed and acknowledged call bell use. R42 expired 10/17/12. 2. All residents are at potential risk of not being accommodated with call bell placed within reach. All residents audited on 10/5/12 and result was all call bells within reach.	10/5/12 10/5/12

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F 246	Continued From page 5 revealed the resident to be in bed on his right side. The call bell was caught in the side rail on left side of the bed and hanging towards floor, not in reach of resident. Observation on 10/3/12 at 12:38 PM, revealed R42 to be in bed on his right side. The call bell was hanging off left side of the bed, out of reach. An additional observation at 1:09 PM revealed the call bell remained out of reach.	F 246	3. All nursing staff inserviced that call bells must be within reach, accessible and instruct resident on usage. 4. Random audits will be completed to verify call bells are within reach. Audits will be conducted monthly and reported at Quarterly QI (Attachment I).	11/30/12 12/15/12
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interviews, it was determined that the facility failed to ensure that one (R79) out of 25 sampled residents received an ongoing program of activities designed to meet the physical, mental and psychosocial well-being of the resident. Findings include: R79 was admitted to the facility on 3/8/12 with diagnoses of Alzheimer's disease, senile dementia, anxiety state, depressive disorder, personal history of fall, difficulty walking, hypertrophy prostate, primary angle-closure glaucoma, closed fracture unspecified part neck femur.	F 248	F248 483.15 (f) Activities Meet Interests/Needs of Each Resident 1. R79's Activity Assessment was updated (Attachment J) to reflect significant change in status-decline and new orders for comfort care (Attachment K). R79's Activity Care Plan was updated to reflect significant change in status-decline (Attachment L). R79's care plan updated to include activity cart (Attachment L). R79's Section F of MDS (Activities Section) updated to include significant change-decline (Attachment M). 2. An audit was completed on all cognitively impaired residents and long term care residents to evaluate accurate activity assessments, care plans and participation logs (Attachment N).	11/2/12 11/2/12

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F 248	Continued From page 6 A facility Assessment of Interests, Talents & Skills for R79 was completed by an activity assistant on 3/9/12. R79 was assessed to have computer, reading or books on tape, traveling and newspaper and books as hobbies. The word newspaper was circled. The Admission Minimum Data Set (MDS) Assessment for R79, dated 3/12/12, revealed under Section F, Preferences for Customary Routine and Activities, item F0300, Should Interview for Daily and Activity Preference be Conducted staff entered a code of 1/Yes an interview should be conducted for Daily Preferences. MDS Item 0500 Interview for Activity Preferences asks the resident questions regarding preferences while he is in the facility. The following information gathered by staff indicated that having books, newspapers, and magazines to read, listening to music he likes, being around pets, keeping up with the news, doing favorite activities, going outside to get fresh air when the weather is good and participating in religious services or practices were all coded as being very important to R79. For MDS item F0600, the primary respondent for this information was family or significant other. The MDS further assessed the Cognitive Skills for daily decision making as a 3, indicating he was Severely impaired - never/rarely made decisions. Observations of R79 from 10/1/12 to 10/9/12 (morning and/or afternoon up to 3:30 PM) revealed that R79 nearly always was sitting in a wheelchair for long period of time alone with little staff interaction. Resident observations:	F 248	3. Inservice all activity staff on accurate Activity Assessments, Care Plans and Participation Logs. Activity staff will also be inserviced on documenting refusals accurately on the Activity Log. 4. Random audits will be completed monthly to evaluate Activity Assessments completed to address cognitive impairment and current care plans (Attachment O).	11/30/12 12/15/12

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F 248	Continued From page 7 On 10/1/12 at 9:45 AM, R79 was sitting in his wheelchair near the doorway of dining room, no reading material music playing in common area. On 10/2/12 at 1:45 PM, the resident was sitting near nurses station head tilted down, eyes closed. On 10/2/12 at 1:50 PM, E21, Activity Assistant, asked R79 if he wanted to listen to music but he refused. E21 walked away, no other activity was offered. On 10/3/12, R79 had no activities from 9:00 - 9: 47 AM. Observations continued until 11:35 AM when R79 was observed with a local free paper. On 10/5/12, an afternoon observation of R79 was that he was reading the same local paper he had on 10/3/12 On 10/9/12 at 9:22 AM - 10:10 AM, R79 was sitting in a wheelchair in the hallway by himself, without any reading material, music or tapes. Observation of R79's room revealed there were 2 magazines and one unopened piece of mail on the overbed table. R79's Activities Care Plan dated 3/16/12 updated 6/11/12 and 9/11/12 identified the following concerns: I am receiving therapy to help me get stronger, however, due to memory recall, I am having difficulty knowing what to do and I am social and may need socialization and activity participation. The goal identified was, I will find opportunities for participating in activities of my choosing for socialization. Approaches included: Activities will	F 248		

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F 248	Continued From page 8 provide me with the monthly activity calendar, The activity staff can invite me to activities but will honor my wishes if I do not want to participate and If I am unable to attend group activities, I would like to receive 1-1 and/or activity cart visits several times a week offering me books, magazines, puzzles, crosswords and other games. Actvities Progress Notes dated 9/11/12 revealed R79 appears to sleep more and it was sometimes harder to engage him in activities. If you speak to him by her (his) ear and in a calm unhurried manner, you will normally get an agreeable response from him. If he is startled, he may respond aggressively. He enjoys bowling, ball toss an even painting. There are days when he strikes up conversations with others and shakes their hands. There is strong support from his wife. Interview with E20 (Activity Director) on 10/3/12 at 12:45 PM revealed that she did not know who was to provide reading materials for this resident. Staff interview with E21 (Activity Assistant) on 10/3/12 at 12:50 PM revealed that it was not known if the family provides reading materials; specifically a newspaper. At 1:00 PM, E21 confirmed that the resident is given the paper every day. R79 was observed to be reading the same free local paper on 10/3/12 and 10/5/12. During staff interview on 10/5/12 12:05 PM, E20 was asked to describe the 1:1 activities that are offered to R79 if he does not attend group activities. E20's response was that we try to involve him, and socialize with him, but it is not always written down.	F 248		

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F 248	Continued From page 9 R79's Activity Participation Logs for the period 9/1/12 through 10/4/12 were reviewed. There were activities that were assessed in the MDS dated 3/12/12 as being important to him that included going outside, pet visits, music, having books, newspapers, and magazines. Many of the assessed activities occurred minimally or not at all. Additionally, according to R79's plan of care, if he was unable to attend group activities he would like to receive 1-1 and/or activity cart visits several times a week offering me books, magazines, puzzles, crosswords and other games. According to R79's Activity Participation Log he did not receive any activity cart visits during the 35 day period.	F 248		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 483.20 (d) (k) (1) Develop Comprehensive Care Plans 1. R44 was discharged 10/4/12. R113 was discharged 10/18/12. R26 cannot retroactively do a care plan for March, 2012; the care plan for incontinence was put in place 6/5/12 (Attachment P). R8's care plan was updated to include weekly weights, Glucerna (nutritional monitor) (Attachment Q). 2. All facility physician/MD consults will be reviewed by the Charge Nurse /designee and all new diagnoses i.e., anxiety will be transcribed as an MD order. All MD orders will be reviewed by Charge Nurse/designee and the plan of care will be updated. All residents with toileting plans will have a urinary incontinence care plan.	10/30/12 11/30/12

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F 279	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a comprehensive care plan for an identified need for four (R44, R113, R26 and R8) out of 25 sampled residents. Findings include: 1. Cross refer F325 example #1. Review of R44's record revealed she had a significant weight loss and was not consuming enough calories to increase or maintain her weight. Review of R44's physician orders revealed an order dated 8/23/12 for "(psychiatric) consult for depression". On 8/23/12 R44 had a psychiatric consult. Review of the consult report revealed R44 was assessed with moderate depression and anxious. This report also documented under "Clinical signs, and maladaptive behaviors" that R44 was " Patient afraid to eat as it causes constipation. She is not hungry she is anxious as she is not in control of her medications. She is depressed as her fracture is not healing. R44 was not enjoying reading or watching TV as she had in the past. R44's fracture of bone near hip has caused her to leave her assisted living apartment and this has affected her mood." The patient management recommendations on the consult report documented "Pt needs to feel in control of her meds. How they look what they	F 279	The facility will have a roster indicating residents on toileting plans which will be reviewed by Charge Nurse/designee to update the care plan (Attachment R). The Monthly/Weekly Weight Recap Sheet will be reviewed by RN/designee and approaches added to the care plan for significant weight changes and interventions (Reference Attachment A). 3. All nurses will be inserviced on reviewing Physician Consult and all new diagnoses will be added by documentation of a physician order. All physician orders will be reviewed by Charge Nurse/designee with care plan updates. The Charge Nurse/ designee will review toileting plans and implement care plan of urinary incontinence. The Monthly/Weekly Weight Recap Sheet will be reviewed and the Charge Nurse/designee will add approaches to the care plan for significant weight changes and interventions. 4. A monthly audit will be done to evaluate care plan updates per review of new orders, toileting plan, MD consults, and change in condition to verify care plans are accurate and updated (Attachment S).	11/30/12 12/15/12

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F 279	Continued From page 11 are for and when she takes them. She needs encouragement to eat more and verbally connect it to her healing of her fracture. ...". Review of R44's care plans with E3 (Assistant Director of Nursing) and E7 (Registered Nurse Assessment Coordinator) on 10/8/12 at 11:55 AM confirmed the facility failed to develop a care plan for R44's anxiety with interventions to address concerns identified from R44's psychiatric consult. 2. Cross refer F329 example #3. R113 was admitted to the facility on 9/12/12 for rehabilitation services. The resident had admission physician orders for Restoril (hypnotic) 15 mg at bedtime as needed for sleep. Review of the September 2012 Medication Administration Record (MAR) indicated R113 used Restoril on 914, 9/15, 917, 9/18, 9/19, 9/22, 9/23, 9/24, 9/27, 9/28, and 9/29. All noted on back of the MAR with reason for use and positive effect. An interview on 10/3/12 at 3 PM with E7 confirmed that there was no care plan for difficulty sleeping. 3. R26 was admitted to the facility on 12/18/11 with diagnoses including diabetes mellitus type II, hypertension, osteoporosis, macular degeneration, spinal stenosis, osteoarthritis, and gastrointestinal bleeding. The significant change Minimum Data Set (MDS) assessment dated	F 279		

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F 279	Continued From page 12 3/5/12 documented that R26 was moderately impaired for daily decision making, required extensive assistance of one staff person for toileting, and was always incontinent urine. Record review revealed a "Bowel and Bladder Training Assessment" in addition to a three day voiding diary which revealed a toileting plan of every two hours. Record review lacked evidence of a care plan for urinary incontinence. An interview with E7 (RNAC) on 10/8/12 at approximately 11:30 AM confirmed that the facility had no evidence of a care plan. The subsequent quarterly MDS assessment dated 6/5/12 documented improvement in R26's cognitive status as well as improvement in urinary incontinence to frequently incontinent of urine. 4. Cross refer 325 example #2. Upon readmission to the facility R8 was assessed by the dietician on 6/21/12 and determined to be at a high nutritional risk. Record review revealed an initial nutrition assessment completed by E12 (Registered Dietician) that included recommendations for weekly weights, Glucerna (nutritional supplement), and monitor. Although the facility implemented a care plan for potential / actual alteration in nutrition, the care plan lacked approaches for monitoring weights, meal intake and snack intake for R8. Findings reviewed on 10/10/12 at approximately 11 AM with E1 (Administrator), E2 (Director or Nursing), and E3 (Assistant Director of Nursing).	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 13 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to review and revise care plans for three (R44, R8 and R79) out of 25 sampled residents. Findings include: 1a. Cross refer F325, example # 1. On 10/1/12 at 12:05 PM while performing the dining observation R44 was not observed in her room or in the main dining room. The dining staff stated that R44 had lunch in the AL (Assisted Living) dining room. On 10/2/12 R44 was observed eating in the AL dining room. On	F 280	F280 Right to Participate Planning Care Revise Care Plan 1. R44 was discharged to Assisted Living 10/4/12. The facility is unable to retroactively revise care plan regarding meals in Assisted Living as an intervention. R8's care plan was updated to include weekly weights, cueing and assist at meals and sit near staff (Attachment Q). R79's care plan was updated to reflect long term care resident and updated with significant change-decline (Attachment L). 2. All activities for long term care residents will be audited to reflect long term care needs (Attachment T). Policy developed for Location of Resident Meals to ensure skilled care residents consume meals on the skilled unit (Attachment U). A form as developed to place in the facility's admission packet to inform residents of location for meals (Attachment V). All resident orders will be reviewed by Charge Nurse/designee and care plan will be updated. 3. Activity staff will be inserviced on updating/revising care plans from therapy to long term care. Nursing staff will be inserviced on new policy for location of resident meals and admission form used to notify residents for location of meals. In addition, the Charge Nurse/designee will review all orders and revise the care plan.	11/1/12 11/15/12 11/30/12

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F 280	Continued From page 14 10/4/12 at 12:15 PM E13 (speech pathologist), E7 (Registered Nurse Assessment Coordinator) and surveyor observed R44 eating in the AL dining room. E13 and E7 stated R44 received her lunch and dinner meals in the AL dining room because her consumption of food and mood increases when she is with her friends in the AL dining room. On 10/4/12 at 10:32 AM review of R44's nutritional status and weight loss with E12 (dietician) revealed R44 ate her lunch and dinner meals in the AL dining room not in the skilled facility dining area. R44 had a care plan for Potential/actual alteration in nutrition related to her congestive heart failure and fracture and poor po intake. with approaches/interventions that included -diet as ordered -assist at meal (as needed) Review of this care plan with E12 (dietician) on 10/4/12 10:32 AM revealed that the facility failed to review and revise R44's care plan documenting R44 eating in the AL dining room as an approach/intervention. 1b. R44 had a care plan for "Dysphagia with interventions that included: -treatment for dysphagia -change diet to pureed On 8/24/12 R44 had a physician order for "Mechanical soft ground meats, extra sauces and gravies". Review of R44's care plan with E13 (Speech	F 280	4. Activities Director will audit care plans monthly to verify revision from therapy to long term care monthly and reported to Quarterly QI (Attachment O). A random audit will be completed monthly to verify revision of the care plan per review of orders and reported at Quarterly QI (Attachment S).	12/15/12

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F 280	Continued From page 15 Pathologist) on 10/4/12 at 11:20 AM confirmed the facility failed to review and revise R44's dysphagia care plan to include this diet change. 2. R79 was admitted to the facility on 3/8/12 for therapy and later became a long term care resident. An activity care plan was developed for R79 on 3/16/12. The care plan form indicated in a Quarterly update column that the information was updated on 6/11/12 and 9/11/12. An interview with E20 (Activity Director) on 10/10/12 at 8:55 AM confirmed that the care plan was not revised to reflect that R79 became a long term care resident. Additionally, the care plan did not include the fact that due to his impaired vision related to glaucoma, R79 required large print, 14 point font and wears glasses. This information was important as reading the newspaper and books were documented on the MDS, dated 3/12/12, as being very important activity preferences for R79. 3. Cross refer F325 Example #2. Review of R8's medical record revealed a physician's order dated 8/13/12 that stated "weekly weights please" and "please increase cueing and assist at meals, sit near staff." R8 had a care plan implemented for potential/actual alteration in nutrition. The facility failed to update and revise the care plan to include the new interventions ordered by the physician on 8/13/12.	F 280		

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F 280	Continued From page 16 Findings reviewed with E1 (Administrator), E2 (Director or Nursing), and E3 (Assistant Director of Nursing), on 10/10/12 at approximately 11:00 AM.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other documentation as indicated it was determined that the facility failed to ensure that three (R11, R44 and R80) out of 25 sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility failed to assess R11 after the resident had no bowel movement (BM) activity for three days and failed to implement the interventions as ordered. The facility failed to accurately assess R44's pain before and after the administration of pain medication. The facility failed to ensure that finger stick blood sugar test was completed as ordered for R80. Findings include: Bowel Monitoring: Review of the facility's protocol titled "Bowel	F 309	F309 Provide Care Services for Highest Well Being 1. R11's bowel movement protocol intervention cannot be retroactively implemented. R44 was discharged 10/4/12, and facility cannot retroactively assess pre/post pain assessment. R80 was discharged 8/16/12, and facility cannot retroactively do a Finger Stick Blood Sugar (FSBS). 2. The laxative list is done by Charge Nurse/designee after accurate review of Certified Nursing Assistant flow records. A Nurse Alert Form will be implemented to alert nurses of the next time a medication, treatment or procedure is due on a new admission/ readmission (Attachment W). A PRN tab will be on the Medication Administration Record (MAR) and will be used to identify pre/post pain follow-up (Attachment X).	11/30/12

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F 309	Continued From page 17 Monitoring Protocol" documented - Any resident that is documented as no bowel movement (BM) X 3 days will be placed on the laxative list. The nurse should look at residents who have only had a small bowel movement documented in 3 days as well as this may indicate a need for a laxative. - Milk of Magnesia (laxative) will be given by the 3-11 shift. This will be documented on the laxative list and on the as needed medication administration record. - If Milk of Magnesia is ineffective, a Dulcolax (laxative) suppository will be given by 11-7 shift nurse. This will be documented on laxative list and the as needed medication administration record. - If still ineffective, a Fleets enema (saline laxative) will be given by the 7-3 shift nurse and documented. 1. The most recent quarterly Minimum Data Set (MDS) assessment dated 7/9/12 documented that R11 was totally dependent on staff for mobility and was always incontinent of bladder and occasionally incontinent of bowel. A care plan for constipation was initiated on 12/14/10 and integrated the following interventions: - Administer Senokot (stool softener), monitor its effectiveness and for any adverse side-effects. Report any problems to the physician. - Assess for signs and symptoms of constipation. - Follow the facility bowel protocol if signs and symptoms of constipation present. - Monitor and record my bowel movements	F 309	3. All nurses will be inserviced on the Nurse Alert Form, PRN tab for pre/post pain assessment, and accurate review of Nursing Assistant Flow records and follow-up with bowel movement protocol. In addition, PRN tab will be used to alert pre/post pain assessment. 4. An audit of pre/post assessment compliance and bowel protocol compliance will be done monthly and reported to Quarterly QI (Attachment Y). A monthly audit will be done of new medications timely administration to verify monthly compliance and reported at Quarterly QI (Attachment Z).	11/30/12 12/15/12

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F 309	Continued From page 18 each shift. Report any abnormalities to the nurse. Review of the August 2012 and September 2012 Physician's Order Form and the medication Administration Record (MAR) documented that R11 was ordered and administered Senokot tablet by mouth routinely at bedtime for constipation. Review of the certified nursing assistant's (CNA) documentation on the medical record titled "Bowel," for July 2012 and August 2012: Beginning on 8/7/12 (day shift) through 8/10/12 (night shift), a total of 12 shifts, there was no BM activity. Review of the MAR revealed the bowel protocol was not initiated and no additional medication was administered for constipation. Beginning on 8/15/12 (night shift) through 8/19/12 (evening shift) there was either no BM activity or small activity. Review of the MAR revealed the bowel protocol was not initiated and no additional medication for constipation was administered. Beginning on 9/9/12 (night shift) through 9/13/12 (evening shift), a total of 15 shifts, there was no BM activity. Review of the MAR revealed the bowel protocol was not initiated and no additional medication for constipation was administered. Beginning on 9/15/12 (night shift) through 9/18/12 (evening shift), a total of 12 shifts, there was no BM activity. Review of the MAR revealed the bowel protocol was not initiated and no additional medication for constipation was administered.	F 309		

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F 309	Continued From page 19 Beginning on 9/20/12 (night shift) through 9/25/12 (evening shift), a total of 18 shifts, there was either no BM activity or a small BM was documented (2 shifts). Review of the MAR revealed the bowel protocol was not initiated and no additional medication for constipation was administered. During an interview on 10/2/12 at approximately 11:00 AM, E10 (charge nurse) confirmed that R11's bowel activity had not been adequately monitored during the specified time periods and that the appropriate interventions (e.g. MOM and Dulcolax suppository) had not been implemented as the bowel protocol indicates. E10 also confirmed that small bowel movements are not adequate enough to be considered when assessing the need to initiate the bowel protocol for constipation. An interview with E2 (Director of Nursing) and E3 (Associate Director of Nursing) on 10/09/12 at approximately 1 PM confirmed the above findings. 2. The facility's policy and procedure for "Pain Management" stated "3. At minimum, each resident will be asked if he/she is experiencing pain (or observed for behaviors indicating pain) once per shift while awake (7A-3P; 3P-11P; 11P-7A). If pain is indicated which requires the use of a prn intervention, this will be documented on the pain flow sheet. Pain will be assessed the numerical score of 1-10... 4. Resident will be re-assess for pain within two hours of implementation of an intervention (unless specified otherwise by physician) to determine effectiveness of the intervention. Effectiveness	F 309		

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F 309	Continued From page 20 will be documented on the Pain Flow Sheet with a numerical score and documented in the chart. If the intervention,i.e. pain medication, is ineffective, the Health Care Provider will be contacted for further orders." R44 was admitted to the facility with diagnoses that included osteoarthritis and subtrochanteric/introchanteric fracture of the right hip fracture status post open reduction internal fixation. R44 had a physician order dated 8/9/12 for "Tylenol 325 mg tabs 2 by mouth every 4 hours for pain as needed". R44 had a care plan for "Alteration in Comfort: Pain R/T Right Hip Fracture and Osteoarthritis/Osteoporosis" initiated on 8/9/12 with interventions that included: - Administer my analgesics as prescribed monitor effectiveness. -Monitor adverse side-effects. Report any problems with uncontrolled pain to MD immediately -Assess for pain at least every shift using a pain scale. Document severity, interventions implemented, and outcomes on my pain flow record. Review of R44's Pain Flow sheet for September 2012 stated "Complete this form if resident: 1. Requests pain medication 2. Complains of pain... Pain and efficacy of intervention must be documented with a numerical score:..." Review of R44's Pain Flow Sheet for September 2012 revealed this form was left blank.	F 309		

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F 309	Continued From page 21 Review of R44's Medication Administration Record revealed she was administer Tylenol for pain on the following dates with the following assessments: -9/4/12 at 2:00 PM for leg pain that was documented at 3:00 PM (+) results -9/8/12 at 6:30 AM for complaints of leg pain at 9:00 AM (+) results -9/17/12 4:30 PM for complaints of right ear ache at 7:00 PM (+) results There was no evidence that the facility assessed R44's pain level using a numerical score before and after she was administered the Tylenol for pain on the above dates. Review of R44's nurses notes failed to have documentation of R44's pre and post pain evaluation for the Tylenol administration using a numerical score. Review of R44's pain medication assessment with E3 (Assistant Director of Nursing) on 10/2/12 at 3:10 PM confirmed the facility failed provide pre and post pain assessments when administering medications using the numerical pain score. 3. R80 was admitted to the facility on 7/11/12 with diagnoses including chronic obstructive pulmonary disease, congestive heart failure, dysphagia, pleural effusion, atrial fibrillation, hypertension, mixed hyperlipidemia, depression, anxiety, obstructive sleep apnea, and diabetes mellitus type II. An admission order, dated 7/11/12, included FSBS to be completed before	F 309		

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F 309	Continued From page 22 meals and at bedtime and to call physician for blood sugar greater than 400. Review of the July 2012 MAR for 7/11/12 lacked evidence that the FSBS scheduled prior to dinner at 4:30 PM was completed as ordered. An interview with E2 (Director of Nursing), on 10/3/12 at approximately 12 noon confirmed the findings.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide services to restore or maintain bladder function for two (R112 and R49) out of 25 sampled residents. Findings include: The facility's policy for Incontinence Management documented that a resident who is incontinent of bladder/bowel will receive the appropriate treatment and services to restore as much normal bladder/bowel function as possible. Each resident will be assessed for bladder/bowel functioning. Following the assessment, individualized goals will be established to restore	F 315	F315 No Catheter, Prevent UTI, Restore Bladder 1. R49 was discharged 8/28/12. R112 currently has a foley catheter for wound healing (Attachment AA). 2. The facility revised its bowel and bladder voiding diary policy from 3 days to 2 days to verify improved compliance (Attachment BB). The facility implemented voiding dairy tracker to review start/stop of voiding diary and toileting plan was implemented (Attachment R). 3. All nurses will be inserviced on policy and procedure and form revision on bowel and bladder voiding diary. This includes changes from 3 days to 2 days for voiding diary along with review of voiding diary/toileting plan master tracker. 4. A monthly audit will be completed to verify voiding diaries are accurately completed and toileting plan implemented (Attachment CC).	9/20/12 11/30/12 11/30/12 12/15/12

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F 315	Continued From page 23 or improve bladder/bowel functioning. The procedure included all admissions / re-admissions would have a bowel and bladder training assessment completed and a 3-day voiding diary initiated. If a resident scores 1-14 an incontinence assessment must be done. Upon completion of the voiding diary, the best toileting plan for the resident will be determined. 1. R49 was admitted to the facility on 6/11/12 with diagnoses which included fractured arm, fractured foot, Alzheimer disease, thyroid disorder and osteoporosis. The admission Minimum Data Set dated 6/18/12 documented the resident needed extensive assistance with one person for toileting, was always continent of urine, and not on a toileting program. Review of the June 2012 CNA (Certified Nursing Assistant) documentation sheets confirmed that the resident was always continent of urine. The Bowel and Bladder Training Assessment dated 6/19/12 scored a 7 (candidate for toileting timed voiding). A Medicare payment MDS, dated 7/8/12, documented that R49 now had occasional urinary continence and was not on a toileting program. No further assessment of this change was found. Review of the July 2012 CNA documentation sheets revealed that starting 7/17/12 through 7/31/12 R49 was documented as being incontinent of urine on all but two shifts.	F 315		

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F 315	Continued From page 24 Clinical record review revealed the resident was having an acute illness that was eventually diagnosed as pneumonia that resulted in a significant change in function during the above period of time. The facility completed a significant change MDS dated 7/29/12 that documented R49 needed extensive assistance with 2 persons for toileting, was always incontinent of urine and was not on a toileting program. The Bowel and Bladder Training Assessment dated 7/28/12 scored 15 (poor candidate for schedule or retraining). The facility developed a care plan for incontinence on 7/29/12 with an approach of offering toileting/check and change every 2 hours and as needed on request. Review of the August 2012 CNA documentation sheets revealed that R49 was continent 10 out of 82 opportunities. The resident was admitted to the facility's Assisted Living (AL) unit on 8/28/12. There was no evidence that the facility attempted to restore bladder function for R49 after it was diminished during an acute episode of pneumonia. Interview with E2 (Director of Nursing), E3 (Assistant Director of Nursing, and E7 (Registered Nurse Assessment Coordinator) on 10/9/12 around 11 AM confirmed there was no evidence of reassessment of R49's bladder continence after the acute episode of pneumonia with antibiotic therapy. It was stated that they believed the resident was doing much better in	F 315		

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F 315	Continued From page 25 the AL with continence but was wearing incontinence pads. 2. R112 was admitted to the facility from assisted living on 9/13/12 after a fall the required transport to the emergency room. A Bowel and Bladder Training Assessment, dated 9/13/12, indicated the resident scored an 11 (candidate for toileting timed voiding). The Admission MDS, dated 9/18/12, documented the resident had impaired cognition, was dependent of staff for toileting, was not on a toileting plan and was always incontinent of bladder. The Bladder and Bowel Maintenance Form, dated 9/14/12 at 2 PM, documented R112 was incontinent of bladder and bowel. R112's care plan, dated 9/13/12, for urinary incontinence included the approaches; -complete and evaluate 3-day voiding diary -I wear a pull up make sure they are the right size -offer me toileting/check and change every 2 hours. There was no evidence on the clinical record that a voiding diary had been completed. An undated Incontinence Assessment was incomplete but documented the resident was incontinent prior to admission, 1-2 times daily, and was being managed by diapers/pads. Review of the September 2012 CNA documentation revealed that R112 was	F 315		

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F 315	Continued From page 26 incontinent all shifts until a Foley catheter was placed on 9/20/12 for wound healing. There was no evidence the resident was on an individualized toileting plan prior to the Foley insertion. A Bowel and Bladder Training Assessment, dated 9/26/12, scored 19 (poor candidate for schedule or retraining). This assessment listed the resident as incontinent but at that time the resident had a Foley inserted on 9/20/12 for wound healing. This assessment was irrelevant to the resident's care. An interview on 10/4/12 at 10:50 AM with AL nurse E24 LPN revealed the resident needed some assistance to toilet but did use the bathroom. An interview on 10/2/12 at 1:40 PM with E7 RNAC revealed that the facility could not find the 3 day voiding diary assessment and confirmed the incontinence assessment was not completed. She also stated she was not sure how staff completed the bowel and bladder assessment dated 9/13/12 when there had not been enough time to collect the data necessary to complete the assessment. E7 also stated that she thought the resident was incontinent while living in the AL unit. E7 confirmed that there was not evidence that R112 was on an individualized toileting plan prior to the Foley insertion.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 27 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R112) out of 25 sampled residents the facility failed to ensure safety measures were in place to prevent falls and injury. Findings include: R112 was admitted to the facility on 9/13/12 after having a fall in the assisted living (AL) unit of the facility that same day which required an evaluation in the emergency room (ER). The residents diagnoses included closed head injury, HTN, hypothyroidism, spinal stenosis, neuropathy, lung CA, and adrenal insufficiency. The resident's admission MDS, dated 9/18/12, documented the resident had a fall in the last 30 days and in the last 2 to 6 months, the resident was cognitively impaired and was dependent on staff for transfers. R112's care plan, dated 9/13/12, for potential for falls related to impaired mobility, medication, incontinence and pain included the approach of keeping the bed in the lowest position appropriate for the resident. The admission physician orders, dated 9/13/12, included bed low to floor and therapy services. A physician order was obtained on 9/27/12 for a personal alarm on when resident was in bed. Review of the September and October 2012	F 323	F323 Free of Accidents Hazards / Supervision / Devices 1. R112's bed placed in low position and personal alarm placed and functional with "on" position activated, 10/5/12. R112's CNA flow records and care plan reflect low bed and personal alarm when in bed (Attachment DD). R112's bed placed with a laminated identifier at foot of bed (exterior foot of bed panel) for staff to identify low bed position (Attachment EE). 2. A Master Safety Device Log is maintained and reviewed by the Charge Nurse/designee and verified weekly with adjustments as needed (Attachment FF). 3. All nursing staff will be inserviced on low bed laminated identifier, safety device instructions and Master Safety Device Log. 4. A monthly audit will be done to verify safety devices: low bed, bed in proper position and alarms ordered and on and will be reported at Quarterly QI (Attachment GG).	11/2/12 11/5/12 11/30/12 12/15/12

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F 323	Continued From page 28 nurses' treatment record documented "bed low to floor FYI". Review of the September and October 2012 CNA documentation revealed under the section for bed mobility "bed low to floor FYI" and starting 9/27/12 "personal alarm when in bed every shift" which was initialed each shift by staff. Observation of R112 on 10/3/12 at 10:26 AM revealed the resident to be in bed laying on her right side with her eyes closed, the bed was elevated in a high position as if a treatment or care had just been provided. At 10:35 AM the resident's aide, E22, approached the door of the room as the Registered Nurse Assessment Coordinator, E7, was coming down the hall. E22 stated to E7 that the resident was sleeping. E7 looked in the room and they agreed not to wake the resident and both left the area, leaving the resident in the elevated position. A therapist entered the room a short time later and assisted the resident out of bed. There was also no alarm noted to be on the bed. Observation on 10/4/12 9:30 AM revealed the resident was in bed on her back and the nurse was preparing to administer medication. The bed was not in the low position. Observation again at 10:22 AM revealed the bed to not be in the low position. There was not a personal alarm on resident for either observation. An interview on 10/4/12 at 10:30 AM with nurse, E10, provided a demonstration of what a bed ordered to be low to the floor would look like. R112's bed had been much higher than the demonstration. A follow-up interview on 10/5/12	F 323		

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F 323	Continued From page 29 at around 10:30 AM with E10 the above observations were reviewed. The alarm was on the bed at the time, but not attached to the resident as care was being administered.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure acceptable parameters of nutritional status were maintained for two (R44 and R8) out of 25 sampled residents who had a significant weight loss. The facility failed to follow the plan of care for R44 who had a physician order for a therapeutic diet for her dysphagia with aspiration precautions, failed to provide supervision for R44 while eating, monitor I&Os (Input and output), and daily weights. The facility failed to assess weights as required by the policy and procedures for R8. Findings include: Policy and Procedures for Weights, Monthly Weights, and Re-weights	F 325	F325 Maintain Nutrition Status Unless Unavoidable 1. R44 was discharged to Assisted Living 10/4/12. R8's re-weight, meal %, or snack consumption cannot be retroactively corrected. 2. All skilled residents being monitored for i.e., food/fluid intake and weight monitoring will be served meals on the skilled unit (Attachment U). All residents with a diagnosis of Dysphagia, intake/output, daily weights will be supervised on skilled unit for meals (Attachment U). Master roster for all residents on intake/output and placed on alert charting (Attachment HH). Certified Nursing Assistants pick up all trays and monitor in dining room to record fluid intake and meal percentages. Snacks will be designated with a visual cue to prompt staff to offer and document snack consumption. Refusal of snacks will be noted as R and reported to nurse (Attachment JJ).	11/30/12

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F 325	Continued From page 30 It is the policy of (facility) that admission weights will be taken on all health center residents and will be taken every week there after for four weeks... Re-weights will be taken if the resident gains or loses more that (sic) 5 pounds or as ordered by the physician. 4. All monthly weights and re-weights must be dated and initialed on the weight sheet on the day they are done. 5. If a weight gain or weight loss of 5 pounds or greater is noted, notify the designee from dining. 6. Appropriate documentation must be placed in the nurse's notes and/or monthly summary stating the reason for the weight gain or weight loss if known. 7. If the weight loss or weight gain indicates a problem, nursing interventions that are initiated are to be documented in the medical record and on the care plan. 8. It will be the responsibility of the nurse to document the weight in the medical record when the weight is obtained." 1a. R44 was admitted to the facility on 8/9/12 with diagnoses that included subtrochanteric/introchanteric fracture of the right hip fracture status post open reduction internal fixation, acute kidney failure, congestive heart failure, cardiomegaly, atrial fibrillation, hypertension, hyposomoality/hyponatremia, hypothyroidism, cardiac pacemaker and a history of colon cancer. Review of R44's admission Minimum Data Set dated 8/16/12 documented that R44 was independent for eating and did not require assistance . The swallowing and nutrition section documented R44 had coughing, choking during	F 325	3. Nursing staff will be inserviced on policy for meals on skilled unit, Master Intake/Output Roster, Certified Nursing Assistants picking up trays and documenting fluid intake and meal percentages. Also, nursing staff will be inserviced on snack cue to prompt offering, and documenting snack percentage consumption. Inservices will include R documentation for refusal and reported to the nurse. 4. An audit will be done monthly to monitor residents on intake/output, on daily weights to ensure they are on alert charting, if weight loss/re-weight done, Certified Nursing Assistant flow sheet meal/snack %, and diagnosis of Dysphagia/ swallowing and will be reported at Quarterly QI (Attachment II).	11/30/12 12/15/12

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F 325	Continued From page 31 meals or when swallowing meds. This MDS also documented R44 was receiving Speech Therapy. Review of R44's physician orders revealed the following orders: -On 8/23/12 MD order for psych consult for depression. -On 8/24/12 an diet order for "Mechanical soft, ground meats, extra sauce, gravy, and thin liquids." -On 8/30/12 "Speech therapy 5 times a week times 4-6 weeks dysphagia management". Review of R44's care plan revealed: "ADL/Self-care deficits R/T decreased functional mobility R/T hip fracture" initiated on 8/9/12 with interventions that included: -I can feed myself after set-up. -Monitor my intake to ensure my nutritional/fluids needs are met. -Aspiration precautions. I must sit upright at 90 degrees for meals and 30 minutes after eating. Cue me to take small bites/sips. Alternate solids and liquids. allow extra time to swallow each bit/sip... "Potential/actual alteration in nutrition related to her congestive heart failure and fracture and poor po intake" initiated on 8/13/12 with interventions that included: with approaches/interventions that included -diet as ordered -assist at meal (as needed) "I have dysphagia (a swallowing problem) and the potential for aspiration" initiated on 8/10/12 with interventions that included:	F 325		

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F 325	Continued From page 32 -alternate small bites and sips -check my mouth after each meal for pocketed food/debris. Report to nurse any findings. Provide me with oral care to remove the food/debris -Follow my diet as ordered 8/24/12 Mechanical soft, ground meats with extra sauces and gravies and thin liquids -I must eat in an upright (90 degrees), eat slowly, and to chew each bite thoroughly. -I must eat my meals in the dining room where I can be supervised, cued and assisted -Monitor/document/report any shortness of breath, choking, labored respirations, lung congestion, difficulty swallowing, holding food in my mouth, prolonged swallowing time. repeated swallows per bite, coughing, throat clearing, drooling, pocketing food, etc "Dysphagia" initiated on 8/15/12 with interventions that include: -Please see aspiration precautions form -Resident is to remain supervised for all meals Review of the "Aspiration Precautions" form for R44 included: -Take/feed small bites -Alternate solids and liquids when feeling food stuck in throat -Allow extra time to swallow each bite/drink slow pace Review of R44's "Dysphagia Evaluation" revealed her treatment precautions were for "aspiration". Review of R44's nurses notes documented on 8/17/12 " ...Resident had difficulty swallowing crushed meds. Speech therapy aware." On	F 325		

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F 325	Continued From page 33 8/27/12 the nurse notes documented Resident stated "I am not hungry. I feel like it gets stuck in my throat." Review of R44's psych consult dated 8/28/12 revealed "Patient afraid to eat as it causes constipation. She is not hungry. She is anxious as she is not in control of her medication...." The patient management recommendations stated "She needs encouragement to eat more and verbally connect it to her healing of her fracture." Review of the Nutritional Progress notes dated 9/13/12 revealed "Intake 33%-2 meals eaten off floor yesterday and breakfast taken at 50%. Weight loss persists. supplements taken poorly intake improved slightly. She likes to eat off floor. Likes to eat with friends..." 9/19/12 "...eats lunch and dinner off floor...' On 10/1/12 at 9:10 AM R44 was observed in her room eating her breakfast without supervision. On 10/1/12 at 12:05 PM while performing the dining observation R44 was not observed in her room or in the main dining room. The dining staff stated that R44 had lunch in the AL (Assisted Living) dining room. On 10/2/12 at 12:05 PM R44 was observed eating her lunch in the AL dining room not in the skilled section of the facility. On 10/4/12 at 10:32 AM review of R44's nutritional status and weight loss with E12 (dietician) revealed R44 ate her lunch and dinner meals in the AL dining room not in the skilled facility dining area where staff are available for assistance and supervision. The facility and R44 felt that eating with her friends in the AL dining	F 325		

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F 325	Continued From page 34	F 325		

room would decrease her depression and increase her caloric intake. In the AL dining room there was no one to supervise, cue, assist her and no one monitors her food and fluid consumption.

On 10/4/12 at 12:15 PM E13 (speech pathologist), E7 (RNAC) and surveyor observed R44 eating in the AL dining room. R44 stated she had corn chowder and a bacon, lettuce and tomato sandwich. E13 immediately stated R44's meal was not the recommended diet ordered by the physician for her. E13 and E7 continued to state that R44 had dysphagia and does not have an order to discontinue the dysphagia care plan. R44 was on aspiration precautions and should be supervised with her meals. E7 continued to state that she has never approved for R44 to go to the AL dining for meals without supervision. R44 was to have ground meats. The AL dining area will not ground meat they will only go as low as chop meats for the residents. There were no staff in the AL dining room to monitor or assist residents.

An interview with E14 (dietary services for AL) on 10/4/12 at 12:20 PM revealed no one monitors R44 while she is eating or documents her meal intake when in the AL dining room.

1b. R44 had a physician order dated 8/9/12 for "daily weights".

Review of R44's "Vital signs and Weight Flow Sheet" revealed on 8/14/12 R44 weighted 151.3 pounds on 8/15/12 (24-hours later) R44 weighted 145.8 lbs. a re-weight was not conducted. The facility failed to reweigh R44 when she had a weight loss of 5.5 lbs in a 24-hour period

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F 325	Continued From page 35 according to the facility's policy. When R44 was discharged from the facility she weighed 127.2 lbs. Review of R44's "Vital signs and Weight Flow Sheet" revealed the facility failed to weigh R44 on the following days; 8/13/12, 8/16/12, 8/18/12, 8/31/12, 9/2/12, 9/7/12, 9/10/12, 9/13/12, 9/15/12, 9/21/12, and 9/25/12. Review of R44's weights with E7 (RNAC) and E12 (Dietician) on 10/8/12 at 12:25 PM revealed the CNAs weigh the residents. They do not have access to a residents previous weight so they do not know if there was a weight loss or gain. The CNA gives the residents weights to the charge nurse. Someone puts the weights on the residents "Vital signs and Weight Flow Sheet" and that was when a weight loss or gain would be identified. E7 and E12 confirmed the facility failed to perform daily weights and failed to reweigh R44 when she had over a 5 pound weight loss in a 24-hour period. 1c. Review of R44's physician orders revealed an order dated 8/12/12 "Lasix 40 mg one by mouth every day for edema *start 8/12/12." On 8/23/12 for R44 had an physician order for "Monitor I&O daily each shift R44 had a care plan for "I am at risk for dehydration related to diuretic (Lasix) use" initiated on 8/11/12 with interventions that included "8/23/12 Monitor I&O each shift each day." Review of CNA documentation of meal percentages revealed from 9/10/12 through	F 325		

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F 325	Continued From page 36 10/3/12 R44 was eating her meals in the AL dining room. No percentages of food or fluid consumption was documented on this form. Review of R44's record with E10 (LPN) on 10/2/12 at 1:35 PM revealed there was no evidence that the facility monitored R44's I&Os every shift as ordered by the physician since her admission. Review of the CNAs flow sheet for September and October 2012 failed to document the need for the CNAs to monitor R44's I&O's. On 10/2/12 at 1:45 PM an interview with E15 (CNA) revealed E15 was R44's CNA for the last two days and R44 was not being monitored for her I&Os. E15 continued to state if a resident was to be monitored for I&O's the facility puts I&O worksheets in the CNA book. R44 did not have the I&O worksheet nor was it documented on her flow sheet. On 10/3/12 the physician wrote an order "Resume I&O's". On 10/4/12 at 10:32 AM review of R44's orders for I&O's with E12 (dietician) revealed she was not aware that R44's I&Os were to be monitored. On 10/4/12 at 12:50 PM an interview conducted with E9 (physician) revealed that when R44 was admitted to the facility she was very sick with nausea, diarrhea and +3 edema in her extremities. R44's wt loss was related to fluid. She had hyponatremia with +3 edema to her extremities. E9 stated he wrote an order for I&Os because he ordered Lasix for her and was	F 325		

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F 325	Continued From page 37 concerned about fluid overload. R44's weights should have been done and her diet should have been followed. E9 continued to state that it was "inexcusable" the facility did not follow R44's orders. E9 stated residents that are admitted to the skilled unit will not be allowed to go to the AL unit until they are discharged from the skilled unit. Review of R44's record with E3 (ADON) on 10/9/12 at 2:30 PM confirmed the facility failed to follow the physician orders for R44's diet, weights, and I&O. The facility did not have a policy and procedure in place addressing residents that are in the skilled unit going to the AL dining room for their meals. E3 confirmed the facility failed to ensure that R44 received the recommended diet as ordered by the physician. R44 was observed eating in her room alone or in the AL dining without supervision. Interview on 10/9/12 at 10:50 AM with E2 (DON) revealed that any resident with dysphagia, requires I&Os or needs to be monitored should not be off the skilled unit. If a resident is admitted to the skilled unit they need to remain there until they are discharged. Cross refer to F514 2. R8 was readmitted to the facility on 6/17/12 with diagnosis that included cerebral vascular accident, urosepsis, and respiratory failure with intubation. R8 was identified as a high level nutritional risk during the initial assessment dated 6/21/12 by the dietitian (E12). Review of R8 ' s MDS dated 6/24/12 stated R8's cognition was severely impaired at the time of	F 325		

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F 325	Continued From page 38 readmission. R8 was totally dependent and required the assistance of one staff person for eating. MDS dated 6/24/12 documented R8's height as 69 inches and weight as 190 pounds. Admission weight documented 6/17/12 on the "Vital Signs & Weight Flow Sheet" a weight of 189.6 pounds. According to the facility's policy, weekly weights for 4 weeks were to be completed upon admission/ readmission to facility. The facility failed to complete week 3 (approximately July 8, 2012) and week 4 (approximately July 15, 2012) weights for R8 according to the "Vital Signs & Weight Flow Sheet." According to "Vital Signs & Weight Flow Sheet" R8's documented weight for 7/1/12 was 180.6 and had decreased by 18 pounds on 8/1/12 to 162.6. The facility failed to reweigh R8 after identifying a severe weight loss and in accordance with the facility's policy. Interview with E10 on 10/2/12 11:20 AM confirmed above information. An interview with E2 (Director or Nursing), and E3 (Assistant Director of Nursing) on 10/09/12 at approximately 1:00 PM confirmed the above findings. Additionally Review of R8 ' s " Meal Percentages " flow sheet revealed the incomplete documentation of the resident's meal consumption for July and August.	F 325		

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F 325	Continued From page 39 R8 had a physician ' s order dated 7/19/12 for a 3 pm snack of cheese and 4 oz of orange juice to be provided to the resident daily. The facility failed to document the percentage of this snack consumption. R8 had a severe weight loss of 18 pounds from 7/1/12 to 8/1/12. The facility failed to accurately document R8 ' s dietary intake. During an interview with E12 (Registered Dietitian), on 10/8/12 at approximately 10:00 AM the above findings were confirmed and E12 who stated the resident often refuses snacks. However, there was no indication of refusal, for the above dates, documented in R8 ' s medical record. Due to lack of reweighs, meal and snack consumption records it was unclear how the facility monitored and ensured R8's nutritional status. Reviewed findings with E1, E2 (Director or Nursing), and E3 (Assistant Director of Nursing) on 10/10/12 at approximately 11:00 AM.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 Drug Regime is Free From Unnecessary Drugs 1. R36, R11, R39, and R19's side effect documentation for psychotropic medications cannot be retroactively documented. R113 was discharged 10/18/12; the facility cannot retroactively document psychotropic side effects.	

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F 329	Continued From page 40 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five (R36, R113, R11, R39 and R19) out of 25 sampled residents, the facility failed to ensure medications were adequately monitored for adequate indication of use and side effects. Findings include: 1a. R36 had a physician's order, originating on 7/24/12, for Ambien (hypnotic medication for the treatment of insomnia characterized by difficulty with sleep onset) 5mg (milligrams) by mouth at bedtime as needed for insomnia. Review of R36's August 2012 and September 2012 Medication Administration Record (MAR) documented that R36 was administered the Ambien almost nightly. R36's care plan for insomnia, initiated on 9/2/10, included a goal that R36 will experience beneficial, restful sleep and be free of adverse side effects. Intervention	F 329	2. All residents on psychotropic medications will have the Behavior Intervention Monitoring Flow Record completed with accuracy, i.e. inclusion of monitoring side effects. 3. All nurses will be inserviced by the Pharmacy Consultant on accurate completion of all aspects of the Behavior Intervention Monitoring Flow Record (BIMFR) (Attachment JJ). 4. A monthly QI will be done to audit accurate completion and monitoring of side effects on Behavior Intervention Monitoring Flow Record (BIMFR) and reported at Quarterly QI (Attachment KK).	11/30/12 11/30/12 12/15/12

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F 329	Continued From page 41 included to administer Ambien as ordered, monitor effectiveness, and adverse side effects. Review of the Behavior/Intervention Monthly Flow Record (BIMFR) for August 2012 and September 2012 although "unable to sleep" was being monitored utilizing this flow record, the facility failed to include this information that R36 was administered the Ambien. In addition, record review lacked evidence that the facility monitored the effectiveness and the presence or absence of the side effect of the use. An interview with E7, Registered Nurse Assessment Coordinator (RNAC), on 10/4/12 at approximately 4:30 PM confirmed the above findings. 1b. R36 had a physician's order, originating on 11/14/11, for Seroquel (an anti-psychotic medication) 100 mg by mouth every morning, 50 mg every day at noon, and 150 mg daily at bedtime for paranoia. Review of R36's August 2012 and September 2012 MAR revealed that R36 was administered the Seroquel as ordered. R36's care plan for psychotropic medication use, initiated on 9/2/10, included a goal that R36 will remain free of drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment for 90 days. Intervention included to administer Seroquel as ordered, monitor/document effectiveness, and adverse side effects. Document same on my BIMFR. Review of the BIMFR for August 2012 and September 2012, although documented that "paranoia and isolating self" were being monitored utilizing this flow record, record review lacked evidence that the facility monitored the presence or absence of the side effect of the use.	F 329		

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F 329	Continued From page 42 An interview with E7 (RNAC) on 10/4/12 at approximately 4:30 PM confirmed the above findings. 2. R113 was admitted to the facility on 9/12/12 for short term rehabilitation services. The facility's pharmacy policy for Medication Monitoring and Management documented that as need (PRN) orders include an indication for use. The resident is monitored for the effectiveness of the medication or possible adverse consequence. Results are documented in the resident's active record. The facility's policy for Behavior Monitoring Form as "it is the policy of Cadbury of Lewes to monitor behaviors and side effects of psychotropic drugs according to OBRA guidelines". The procedure included; each resident on a medication given specifically to alter behavior (psychotropic) will have a behavior monitoring form on the MAR, the behavior for which the drug is given is coded and the nurse writes in the number of episodes of each behavior occurred for each shift, and on the reverse side, there is a code for side effects that should be used on a per shift basis. The resident had admission physician orders dated 9/12/12 for Lexapro (antidepressant) 20 mg daily at bedtime for depression and Restoril (hypnotic) 15 mg at bedtime as needed for sleep. R113 had a care plan for use of an antidepressant medication (Lexapro) initiated on 9/12/12. The goal was "I will be free from adverse reactions related to antidepressant therapy x 90 days". Interventions included "monitor and	F 329		

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F 329	Continued From page 43 document effectiveness and adverse side effects (dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. Document on my behavior flow record (BIMFR) each shift". The BIMFR for September 2012 indicated sadness was being monitored. Side effects to be monitored were listed as anxiety, trouble sleeping, and panic attack. The adverse side effects from the care plan were not included on this form. There was no documentation in the side effect section indicating the side effects were being monitored. Review of the September 2012 MAR documented R113 used Restoril on 914, 9/15, 917, 9/18, 9/19, 9/22, 9/23, 9/24, 9/27, 9/28, and 9/29. All were noted on back of the MAR with reason for use and positive effect. The behavior of insomnia was not included on the BIMFR which also resulted in there being no side effect monitoring for the Restoril. An inteview on 10/3/12 at 3 PM with E7, RNAC, confirmed that there was no monitoring of sleep/insomnia. She also confirmed that the side effects for Lexapro on the BMIFR were not the same as those listed on the care plan 3. R11 had a physician's order, originating 9/15/12, for Seroquel (an anti-psychotic medication) 25 mg (milligrams) to take by mouth at noon and at bedtime for "behaviors/anxiety." Physician's order originating 8/2/12, for Lorazepam (anti-anxiety) 0.5 mg by mouth to be given at bedtime for insomnia. Review of MAR beginning 9/15/12 and ending 10/9/12 revealed that R11 was administered the Seroquel and	F 329		

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F 329	Continued From page 44 Lorazepam as ordered. Review of R11's care plan initiated 9/16/10 for antipsychotic medication use, documented a goal of "I will have no adverse side-effects from the antipsychotic (Seroquel) and anxiolytic (Lorazepam) X 90 days." Interventions included giving Seroquel and Lorazepam as ordered by physician and monitor/document effectiveness, adverse side effects: interventions and outcomes on BIMFR each shift, report any problems to physician. An interview with E2 (Director or Nursing), and E3 (Assistant Director of Nursing) on 10/9/12 at approximately 1:00PM confirmed the above findings. Record review lacked evidence that the facility monitored for the presence or absence of the side effects of the use of Seroquel and Lorazepam during the month of September 2012. 4. R39 had a physician's order, originating 3/12/12, for Seroquel (an anti-psychotic medication) 25 mg to take by mouth two times each day for dementia with behaviors. She also had Lorazepam 0.5 mg by mouth every 8 hours as needed for anxiety. Seroquel administered as ordered during the months of August and September 2012. Lorazepam was administered one time during the month of August 2012. Review of R39's care plan, initiated 9/14/10 for antipsychotic and anxiolytic medication use documented a goal of "I will have no adverse side-effects from the antipsychotic (Seroquel) and anxiolytic (Lorazepam) X 90 days." Interventions	F 329		

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F 329	Continued From page 45 included giving Seroquel and Lorazepam as ordered by physician and monitor/document effectiveness, adverse side effects: interventions and outcomes on BIMFR each shift, report any problems to physician. Record review lacked evidence that the facility monitored for the presence or absence of the side effects of the use of Seroquel and Lorazepam during the months of August and September 2012. An interview with E2 (Director or Nursing), and E3 (Assistant Director of Nursing) on 10/9/12 at approximately 1:00PM confirmed the above findings. 5. R19 was admitted with diagnoses that included hypertension, depression, Alzheimer dementia with behaviors. R19 had a physician order 4/23/12 for "Buspar 10 mg one tablet by mouth bid (twice a day) for anxiety". Review of R19's care plan revealed "I have anxiety at times with interventions that included -Administer my medication (Buspar). -Monitor its effectiveness and adverse side-effects. Report any problems to MD and my family Review of R44's Behavior Monitoring Sheet for September 2012 revealed that the facility failed to monitor R19 side effects for the use of Buspar. Review of R19's record with E19 (RN) on 10/9/12 at 10:05 AM confirmed the facility failed to	F 329		

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F 329	Continued From page 46 monitor R19's side effects for Buspar. On 10/10/11 at approximately 11:00 AM this information was reviewed with E1 (administrator), E2 (DON) and E3 (ADON).	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that the pharmaceutical services provided included the accurate dispensing and administration of medication for one (R43) out of 25 residents sampled. Findings include:	F 425	F425 483.60 (a), (b) Pharmaceutical Service – Accurate Procedures, RPH 1. R43's artificial tears cannot be retroactively dated when opened. R43's name is not on the facility roster; this may have been R44, therefore, the above remains applicable. 2. Medication carts will be audited and all medications requiring date opened will be noted on the box. The facility will have nurses audit each medication cart on Wednesdays to ensure all boxed medications are dated when opened (Attachment LL). 3. Nurses will be inserviced to date all medication boxes when opened. Nurse will audit carts every Wednesday to ensure all box medication is dated when opened (Attachment LL). 4. A monthly QI will be completed to monitor compliance with dating all medication boxes when opened, and reported at Quarterly QI (Attachment MM).	11/30/12 11/30/12 12/15/12

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F 425	Continued From page 47 During medication observation, on 10/3/12 at approximately 4:35 PM, E6 (nurse) administered one drop of artificial tears to each of R43's eyes. The bottle of the artificial tears dispensed date from the pharmacy on 8/3/12, however, failed to have a date when this bottle was opened. An interview with E4, Staff Educator, on 10/4/12 at approximately 9 AM, revealed that when the bottle was opened, the bottle should have been dated and the drops can be administered up to 30 days. However, without an open date, it was unclear when the 30 days would have ended. Findings were reviewed with E2 (Director of Nursing/DON) and E3 (Assistant Director of Nursing) on 10/9/12 at approximately 11 AM.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F431 483.60 (b), (e) Drug Records, Label/Store Drugs and Biologicals 1. The facility discarded and obtained updated pharmacy replacements for: Norolog insulin that had no opened date, the Synthroid blister package that expired 1/20/12, the house stock Novolog insulin without an opened date, two bottles of hydrogen peroxide, one expired 8/29/12 and the other 8/28/12.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 48 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedure it was determined that the facility failed to ensure all medications ready for administration were not outdated. Findings include: The facility's policy and procedures for "Shortened Expiration Dates" revealed "The following medications require nurses to date upon opening as they have shortened expiration dates once opened: -Multi-dose vials=28 days after opening -Insulin vials=28 days after opening..." On 9/28/12 a review of the facility's medication storage was conducted. The following medications were identified as being either out dated or failed to have an open date: 1.On 9/28/12 at 9:55 AM review of the medication cart 2 was completed with E8 (LPN).	F 431	2. The facility will implement that nurses will check for expired medications and verify all boxes opened have a date placed on the box. The nurse will obtain replacements from the pharmacy and discard expired medications and/or bottles opened without a date. The facility nurses will implement this process with each medication pass. The facility will also have nurses audit medication cart and medication room each Wednesday to check for expired medications or medication boxes without a date. 3. Nurses will be inserviced on daily check of medications to discard expired and non-dated opened medications and obtain a replacement from the pharmacy. Nurses will audit cart and medication room each Wednesday to check for expired medications or medications non-dated after opening and discard them. Replacements will be obtained. 4. A monthly random audit of medication carts and medication room will be done to check for non-dated open medications and/or expired medications and will be reported at Quarterly QI (Attachment MM).	11/30/12 11/30/12 11/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085053	A. BUILDING _____ B. WING _____	C 10/10/2012

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F 431	Continued From page 49 -Novolog insulin was opened and failed to have an open date -Synthroid blister package that expired on 1/20/12 2. On 9/28/12 a review of the Medication room was completed at 10:05 AM with E18 (RN). -The refrigerator contained a house stock of Novolog Insulin that was open and failed to have an open date. -Two bottles of Hydrogen peroxide were found in the medication room cabinet one expired on 8/29/12 and the second one expired on 8/28/12 .	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 483.65 Infection Control, Prevent Spread, Linens 1. The facility is unable to retroactively correct the August 2012 and September 2012 Infection Control Trackers by adding the type of organism. The facility employees are unable to retroactively correct proper hand washing.	

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F 441	Continued From page 50 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, reviews of clinical record and facility documentation, it was determined that the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings include: 1. Review of the facility infection control program documentation revealed that for the months of August 2012 through September 2012, the type of organisms infecting residents were not consistently tracked. This lack of information prevented the facility from trending the organisms to determine if there was a pattern of infection that the facility needed to address. An interview with E2 (Director of Nursing) on 10/9/12 at approximately 1:30 PM confirmed that surveillance tracking for the above period of time lacked the type of organism.	F 441	2. The facility Infection Control Tracker will include all organisms acquired from the facility and/or community acquired organisms. The facility LPN/ hospital liaison or designee will use the Delaware Health Information Network (DHIN) or hospital record to obtain community acquired organisms. The facility will list the type of "organism" for all applicable residents on the Infection Control Tracker. Residents are at potential risk of staff using deficient practice with hand washing. The facility will laminate stickers in staff/resident bathroom to prompt staff to adhere to proper hand washing techniques (Attachment NN). 3. Nurses will be inserviced on the Infection Control Tracker and requirement for the "organism" to be listed on the tracker to ensure the facility monitors trends. Nurses will be inserviced on proper hand washing technique and infection control to prevent infection. In addition, staff will be inserviced on location of proper hand washing prompts in resident/staff bathrooms (Attachment NN). 4. A monthly audit QI will be done to check for organisms listed for all resident infections by notation on the monthly infection control tracker and reported to Quarterly QI. A monthly audit using "glow-bug" to evaluate proper hand washing technique will be reported at Quarterly QI (Attachment OO, Attachment PP).	11/30/12 11/30/12 12/15/12

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F 441	Continued From page 51 2. During a medication observation on 10/3/12 at approximately 4:15 PM, E5 (nurse) donned gloves to obtain blood from R111's finger to perform fingerstick blood sugar (FSBS) test via a glucometer device. After using the glucometer, E4 proceeded to wash her hands and used her bare left hand to turn off the faucet instead of using a paper towel. An interview with E5 immediately after the above observation confirmed that she used her left bare hand rather than using a paper towel to turn off the faucet. Findings were reviewed with E4 (Staff Educator) and E3 (Assistant Director of Nursing) on 10/4/12 at approximately 9 AM. 3. During the medication observation on 10/4/12 at 9:12 AM E11(LPN) was observed performing handwashing. E11 washed her hands and turned the faucet off with her clean bare hands. The surveyor reviewed the observation with E11 who immediately rewashed her hands.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 483.75 (I) (U) Resident Records/Accurate Accessible 1. R8's meal percentages and snack percentages cannot retroactively be completed.	

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F 514	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain clinical records for one (R8) out of 25 sampled residents, in accordance with accepted professional standards and practices, that were complete and accurately documented. Findings include: Review of R8 ' s " Meal Percentages " flow sheet revealed for the month of July, no documentation for meal consumption during the breakfast meal for 7/2, 7/9, 7/13, 7/16, 7/17, 7/24, 7/26 and 7/30, the lunch meal 7/2, 7/9, 7/13, 7/16, 7/17, 7/26 and 7/30, the dinner meal 7/5, 7/13, 7/19, 7/23, 7/27 and 7/31. August 2012, no documentation for percentages consumed during the breakfast meal for 8/9 and 8/12, the lunch meal 8/9 and 8/12, the dinner meal 8/2, 8/4, 8/11, 8/12, 8/16, 8/19, 8/28, 8/29 and 8/30. R8 had a physician ' s order dated 7/19/12 for a 3 pm snack of cheese and 4 oz of orange juice to be provided to the resident daily. The facility failed to document the percentage of this snack consumption. This failure occurred the first day after the snack was ordered 7/20/12 and continued throughout the month 7/23, 7/24, 7/25, 7/26, 7/27, 7/30 and 7/31. Review of snack consumption flow sheet revealed multiple omissions of documentation for August 2012. Review of snack consumption flow sheet for September 2012 revealed R8 only has	F 514	2. All residents have potential risk of having inconsistent documentation with meal/snack percentages. In September 2012, the facility implemented that Certified Nursing Assistant will pick up all trays instead of dietary staff to increase consistent meal percentage documentation. The facility will utilize a snack identifier to prompt snack documentation compliance (Attachment QQ). 3. Nursing staff will be inserviced on completion of meal percentage after each meal and completion of snack percentage following snack consumption for those residents with snack orders. 4. A monthly audit will be done to evaluate documentation of meal and snack percentages and reported at Quarterly QI (Attachment II).	11/30/12 11/30/12 12/15/12

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F 514	Continued From page 53 documentation related to percentage of snack consumption on 10 out of 30 days. R8 had a severe weight loss of 18 pounds from 7/1/12 to 8/1/12. The facility failed to accurately document R8 ' s dietary intake. During an interview with E12 (Registered Dietitian), on 10/8/12 at approximately 10:00 AM the above findings were confirmed and E12 who stated the resident often refuses snacks. However, there was no indication of refusal, for the above dates, documented in R8 ' s medical record. Reviewed findings with E1, E2 (Director or Nursing), and E3 (Assistant Director of Nursing) on 10/10/12 at approximately 11:00 AM.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520	F520 483.75 (o) (1) QAA Committee Members/ Meet Quarterly/Plan 1. The facility cannot retroactively correct missed Quarterly QI meetings by the physician on 10/27/11, 1/19/12, and 4/30/12. 2. The facility has completed a Quarterly QI advance schedule for 2013 and provided to physician and QI Committee (Attachment RR). If the physician has a conflict and cannot physically attend a QI Quarterly Meeting, he will participate via conference call which would be indicated on the sign-in sheet as applicable.	11/15/12

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F 520	Continued From page 54 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview it was determined that the facility failed to maintain a quality assessment and assurance committee that met quarterly consisting of the physician designated by the facility. Findings include: An interview with E2 (Director of Nursing/DON) and E3 (Assistant DON) 10/9/12 at approximately 12:30 PM revealed that the physician designated by the facility was not present during the facility's quarterly quality assurance meetings on 10/27/11, 1/19/12, and 4/30/12.	F 520	3. All Quarterly QI Committee members will be inserviced on committee participation requiring physician, Director of Nursing, and (3) other committee members to attend Quarterly QI Meetings. 4. Quarterly QI Sign-In Sheet will be audited for compliance of physician, Director of Nursing and (3) committee members present and reported at Quarterly QI (Attachment SS).	11/15/12 12/15/12

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NAME OF FACILITY: Cadbury at Lewes

DATE SURVEY COMPLETED: October 10, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from September 28, 2012 through October 10, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 34. The stage two survey sample was twenty- five (25).	
3201 **3201.1.0** **3201.1.2**	**Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by**	

Provider's Signature _____ Title Associate Executive Director Date 11/8/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	F157 483.10 (b) Notify of Changes (Injury/Decline/Room, etc.) 1. R8's MD or family notification cannot be completed retrospectively due to timeframe of occurrence, 8/1/12 2. All residents are at potential risk of weight loss and not having the MD or family notified. The facility revised and will be utilizing a Monthly/Weekly Weight Recap Sheet for each resident that evaluates significant weight changes and a designated area on the form to document MD (physician) and family notification (Attachment A). 3. All nurses will be inserviced on the Monthly/Weekly Weight Recap Sheet and proper monitoring and utilization. 4. Random sample audits will be completed to verify MD (physician) and family notification on significant weight changes. Audits will be completed monthly and reported at Quarterly QI (Attachment B).	 11/26/12 11/30/12 12/15/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	F241 483.15 (a) Dignity and Respect of Individuality 1. R42 expired on 10/17/12. R44 was transferred and discharged back to Assisted Living on 10/4/12. The facility cannot retroactively correct R79's inappropriate dress of shirt being unbuttoned and trousers repositioned to secure brief due to a 10/1/12 date of occurrence. The facility cannot correct the timeliness of wiping R79's nasal nares; however, R79's nasal nares was attended to after 1 minute after being observed by a surveyor by E21 (Activity Assistant). R79 cannot be retroactively asked permission to wear clothing protector. R79 had his seating changed to face other residents and placed for socialization. R79 received new orders on 10/11/12 as follows: "Due to resident poking self with fork and knife, only use plastic ware." Also, another new order for R79 on 10/11/12 as follows: "Finger food as much as possible." (Attachment C). R79's care plan was revised to include order changes per Attachment C (Attachment D).	10/11/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	2. The facility will provide tissues in the resident dining room for use by residents or staff as needed. Residents will be checked prior to entering the dining room with adjustments made to clothes accordingly. Residents seating is readjusted to a position that is condusive to socialization. A laminated sign placed on the clothing protector cart with letters "DYA," meaning "Did You Ask" prompt staff to ask resident permission prior to application of clothing protector (Attachment E). The facility will review with the MD/ physician any resident requiring plastic utensils and/or styrofoam disposable items prior to initiating and an order will be written. The facility will also update the plan of care when a resident requires plastic utensils or styrofoam disposal ware. The facility will implement a laminated pictoral of a "SKATE," which means "Stop, Knock, Ask To Enter." The laminated "SKATE" will be placed on the metallic door jam of each resident room (Attachment F). 3. All staff will be inserviced on tissues in dining room, inspection of residents prior to entering dining for proper dress, (i.e. shirts buttoned, briefs secured, etc.) "DYA," "Did You Ask," to apply clothing protector, proper seating of residents to support socialization and "SKATE," "Stop, Knock, Ask To Enter" and knowledge of location of laminated cues.	11/26/12 11/30/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	4. Random audits will be done monthly to evaluate resident seating arrangement conducive to socialization, resident dressed appropriately, nasal/oral cavity clean, "DYA" (Did You Ask) prior to applying clothing protector, follow "SKATE" (Stop, Knock, Ask To Enter) (Attachment H).	12/15/12
		F246 483.15 (3) (1) Reasonable Accommodation of Needs/Preferences	
		1. R42's call bell was readjusted and placed within reach and R42 was instructed and acknowledged call bell use. R42 expired 10/17/12.	10/5/12
		2. All residents are at potential risk of not being accommodated with call bell placed within reach. All residents audited on 10/5/12 and result was all call bells within reach.	10/5/12
		3. All nursing staff inserviced that call bells must be within reach, accessible and instruct resident on usage.	11/30/12
		4. Random audits will be completed to verify call bells are within reach. Audits will be conducted monthly and reported at Quarterly QI (Attachment I).	12/15/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	F248 483.15 (f) Activities Meet Interests/Needs of Each Resident 1. R79's Activity Assessment was updated (Attachment J) to reflect significant change in status-decline and new orders for comfort care (Attachment K). R79's Activity Care Plan was updated to reflect significant change in status-decline (Attachment L). R79's care plan updated to include activity cart (Attachment L). R79's Section F of MDS (Activities Section) updated to include significant change-decline (Attachment M). — 11/2/12 2. An audit was completed on all cognitively impaired residents and long term care residents to evaluate accurate activity assessments, care plans and participation logs (Attachment N). — 11/2/12 3. Inservice all activity staff on accurate Activity Assessments, Care Plans and Participation Logs. Activity staff will also be inserviced on documenting refusals accurately on the Activity Log. — 11/30/12 4. Random audits will be completed monthly to evaluate Activity Assessments completed to address cognitive impairment and current care plans (Attachment O). — 12/15/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	F279 483.20 (d) (k) (1) Develop Comprehensive Care Plans 1. R44 was discharged 10/4/12. R113 was discharged 10/18/12. R26 cannot retroactively do a care plan for March, 2012; the care plan for incontinence was put in place 6/5/12 (Attachment P). R8's care plan was updated to include weekly weights, Glucerna (nutritional monitor) (Attachment Q). 10/30/12 2. All facility physician/MD consults will be reviewed by the Charge Nurse /designee and all new diagnoses i.e., anxiety will be transcribed as an MD order. All MD orders will be reviewed by Charge Nurse/designee and the plan of care will be updated. All residents with toileting plans will have a urinary incontinence care plan. The facility will have a roster indicating residents on toileting plans which will be reviewed by Charge Nurse/designee to update the care plan (Attachment R). The Monthly/Weekly Weight Recap Sheet will be reviewed by RN/designee and approaches added to the care plan for significant weight changes and interventions (Reference Attachment A). 11/30/12

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/10/12, F157, F241, F246, F248, F279, F280, F309, F315, F323, F325, F329, F425, F431, F441, F514, F520.	3. All nurses will be inserviced on reviewing Physician Consult and all new diagnoses will be added by documentation of a physician order. All physician orders will be reviewed by Charge Nurse/designee with care plan updates. The Charge Nurse/ designee will review toileting plans and implement care plan of urinary incontinence. The Monthly/Weekly Weight Recap Sheet will be reviewed and the Charge Nurse/designee will add approaches to the care plan for significant weight changes and interventions. — 11/30/12 4. A monthly audit will be done to evaluate care plan updates per review of new orders, toileting plan, MD consults, and change in condition to verify care plans are accurate and updated (Attachment S). — 12/15/12 F280 Right to Participate Planning Care Revise Care Plan 1. R44 was discharged to Assisted Living 10/4/12. The facility is unable to retroactively revise care plan regarding meals in Assisted Living as an intervention. R8's care plan was updated to include weekly weights, cueing and assist at meals and sit near staff (Attachment Q). R79's care plan was updated to reflect long term care resident and updated with significant change-decline (Attachment L). — 11/1/12

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STATE SURVEY REPORT

NAME OF FACILITY: Cadbury at Lewes

DATE SURVEY COMPLETED: October 10, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
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		3. Activity staff will be inserviced on updating/revising care plans from therapy to long term care. Nursing staff will be inserviced on new policy for location of resident meals and admission form used to notify residents for location of meals. In addition, the Charge Nurse/designee will review all orders and revise the care plan.	11/30/12
		4. Activities Director will audit care plans monthly to verify revision from therapy to long term care monthly and reported to Quarterly QI (Attachment O). A random audit will be completed monthly to verify revision of the care plan per review of orders and reported at Quarterly QI (Attachment S).	12/15/12

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		3. Nursing staff will be inserviced on policy for meals on skilled unit, Master Intake/Output Roster, Certified Nursing Assistants picking up trays and documenting fluid intake and meal percentages. Also, nursing staff will be inserviced on snack cue to prompt offering, and documenting snack percentage consumption. Inservices will include R documentation for refusal and reported to the nurse.	11/30/12
		4. An audit will be done monthly to monitor residents on intake/output, on daily weights to ensure they are on alert charting, if weight loss/re-weight done, Certified Nursing Assistant flow sheet meal/snack %, and diagnosis of Dysphagia/ swallowing and will be reported at Quarterly QI (Attachment II).	12/15/12

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